Washington State Department of Social & Health Services

INVOLUNTARY TREATMENT ACT
PATIENT CLAIM INFORMATION

This form must be completed in triplicate. All providers requesting payment must complete the appropriate sections for each claim submitted for payment. All three copies of this form and the claim form must be routed to the County Involuntary Treatment Office. The County will distribute as follows:

1. Forward the white copy, with the claim form attached, to
   OFFICE OF PROVIDER SERVICES
   PO BOX 9245
   OLYMPIA WA 98504-9245
2. Retain yellow copy in the county.
3. Return the pink copy to the provider of the service.

In the event that a claim is denied, the provider should attach a completed copy of this form to the corrected claim and resubmit to the Office of Provider Services.

SECTION I. THE FOLLOWING INFORMATION MUST BE COMPLETED FOR ALL CLAIMS.

PATIENT NAME	PROVIDER MEDICAL RECORD NUMBER	BIRTHDATE	PATIENT IDENTIFICATION CODE (PIC) NUMBER

SECTION II. HOSPITAL CLAIMS ONLY: TO BE COMPLETED BY HOSPITAL PROVIDERS ONLY.

Check one box or claim will be denied.

- ☐ Patient eligible for public assistance.
- ☐ Patient applied for public assistance eligibility (attach copy of first page of the Application for Benefits, DSHS 14-001(X) or the Request for Assistance, DSHS 14-250(X).
- ☐ Patient's mental state and condition prevents efforts to determine eligibility (72 hours allowed).
- ☐ Patient left the facility prior to the probable cause hearing and cannot be located to complete an eligibility application (72 hours allowed).
- ☐ In the case of a minor child, responsible party refuses to assist in making resources available (case will be referred to the Office of Financial Recovery for collection).

SIGNATURE (TO BE COMPLETED BY HOSPITAL PROVIDER REPRESENTATIVE)	DATE

SECTION III. HOSPITAL CLAIMS ONLY: LENGTH OF STAY EXTENSION

Length of stay extensions is for hospital providers only. Payment will be provided for 14 consecutive days from the probable cause hearing. Extensions beyond that date must be approved by the Western State Hospital (WSH) or Eastern State Hospital (ESH) admissions coordinator or designee. A copy of this approval must be attached to the claim.

☐ Extension approved from: _____ to: _____

☐ Extension request denied: _____

_____

Requested by: _____

_____

SIGNATURE (TO BE COMPLETED BY STATE HOSPITAL ADMISSIONS COORDINATOR)	DATE

SECTION IV. COUNTY DESIGNEE REVIEW: MUST BE COMPLETED BY COUNTY REPRESENTATIVE FOR ALL CLAIMS

_____ 1. DATE OF INITITAL DETENTION: the date patient was originally detained under the provisions of RCW 71.05.

_____ 2. DATE OF REVOCATION DETENTION: the date a conditionally released patient is readmitted for evaluation.

_____ 3. DATE OF RELEASE/TRANSFER/DISCHARGE: the date the patient leaves the community hospital.

SIGNATURE OF COUNTY DESIGNEE	DATE	COUNTY